Quality Measure Information (QMI)

Implementation Guide

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Acronyms and Abbreviations Guide

ACRS	Active Care Relationship Service
APS	All-Payer Supplemental
BCN	Batch Clearance Notice
CCD	Continuity of Care Document
CMS	Centers for Medicare & Medicaid Services
CQM	Clinical Quality Measure
EHR	Electronic Health Record
FHIR	Fast Healthcare Interoperability Resources
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIN	Health Information Network
HL7	Health Level Seven
MDC	Michigan Data Collaborative
MDHHS	Michigan Department of Health and Human Services
MiHIN	Michigan Health Information Network Shared Services
MSMS	Michigan State Medical Society
MUCA	Master Use Case Agreement
PO	Participating Organization
PPQC	Physician-Payer Quality Collaborative
PI	Promoting Interoperability
QMI	Quality Measure Information
QRS	Quality Rating System
SOM	State of Michigan
TDSO	Trusted Data Sharing Organization

Definitions

Active Care Relationship (ACR). (a) For health providers, a patient who has been seen by a provider within the past 24 months, or is considered part of the health provider's active patient population they are responsible for managing, unless notice of termination of that treatment relationship has been provided to HIN; (b) for payers, an eligible member of a health plan; (c) an active relationship between a patient and care manager or other person or organization for the purpose of treatment, payment or operations; or (d) a relationship with a health provider asserted by a patient and approved by such health provider.

Active Care Relationship Service® (ACRS®). The MiHIN infrastructure service that contains information on the TDSOs and health professionals who have an active care relationship with a patient.

Applicable Laws and Standards. In addition to the definition set forth in the Data Sharing Agreement, the federal Confidentiality of Alcohol and Drug Abuse Patient Records statute, section 543 of the Public Health Service Act, 42 U.S.C. 290dd-2, and its implementing regulation, 42 CFR Part 2; the Michigan Mental Health Code, at MCLA §§ 333.1748 and 333.1748a; and the Michigan Public Health Code, at MCL § 333.5131, 5114a.

Common Gateway. The method by which data is sent and received by HIN using different national standard protocols (e.g. NwHIN SOAP, IHE XCA, IHE XDS.b).

Conforming Message. A message that is in a standard format that strictly complies to the implementation guide for this use case.

Data Sharing Agreement. Any data sharing organization agreement signed by both HIN and participating organization.

Electronic Address. A string that identifies the transport protocol, source system, and end point address for communicating electronically with a recipient. A recipient may be a person, organization or other entity that has designated the electronic address as the point at which it will receive electronic messages.

Electronic CQM. CQMs that are specified in a standard electronic format and are designed to use data from Health IT systems for measurement.

Electronic Medical Record or Electronic Health Record. A digital version of a patient's paper medical chart.

Electronic Service Information. All information reasonably necessary to define an electronic destination's ability to receive and use a specific type of information (e.g., discharge summary, patient summary, laboratory report, find patient/provider/healthcare data).

End Point. An instance of an electronic address or electronically stored information.

Exhibit. A use case exhibit or a pilot activity exhibit.

Health Information. Any information, including genetic information, whether oral or recorded in any form or medium, that (a) is created or received by a health professional, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and (b) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual.

Health Information Network (HIN). An organization or group of organizations responsible for coordinating the exchange of protected health information (PHI) in county, state, region, or nationally.

Health Professional or Health Provider. (a) Any individual licensed, registered, or certified under Federal or State laws or regulations to provide healthcare services; (b) any person holding a non-clinical position within or associated with an organization that provides healthcare or healthcare-related services; and (c) people who contribute to the gathering, recording, processing, analysis or communication of Health Information.

HIN Infrastructure Service. Certain services that are shared by numerous use cases. HIN Infrastructure Services include, but are not limited to, ACRS, Health Directory, Statewide Consumer Directory (SCD), and the Medical Information Gateway (MIGateway®).

HIN Services. The HIN infrastructure services and additional services and functionality provided by HIN allowing the participating organization to send, receive, find, analyze or use information to or from HIN as further set forth in an exhibit.

Information Source. Any organization that provides information that is added to a HIN Infrastructure Service.

Master Use Case Agreement. Legal document covering expected rules of engagement across all use cases. Trusted data sharing organizations sign the master use case agreement one time, then sign use case exhibits for participation in specific use cases.

Promoting Interoperability. Using certified EHR technology to improve quality, safety and efficiency of healthcare, and to reduce health disparities.

Message. A mechanism for exchanging data content between the participating organization to HIN services, including search and retrieve.

Message Content. Information which is sent, received, found or used by a participating organization to or from HIN Services, including, but not limited to, PHI, common keys, de-identified data, metadata, Digital Credentials, and data schema. Message Content includes the Message Content Header.

Michigan Health Information Network Shared Services. The HIN for eligible and participating organizations in the State of Michigan.

Patient Data. Any data about a patient or a consumer that is electronically filed in a participating organization or organization's systems or repositories. The data may contain protected health information, personal credit information, or personally identifiable information.

Person Record. Any record located in a HIN infrastructure system that is associated to an individual person.

Send / Receive / Find / Use. Means sending, receiving, finding, or using message content. Sending involves transport of message content. Receiving involves accepting and possibly consuming/storing message content. Finding means querying to locate message content. Using means any use of the message content other than sending, receiving and finding.

Source System. A computer system, such as an electronic health record system, at the participating organization, that sends, receives, finds or uses message content or notices.

Transactional Basis. The transmission of message content or a notice within a time period of receiving Message Content or notice from a sending or receiving party as may be further set forth in a specific exhibit.

Trusted Data Sharing Organization. An organization that has signed any form of documentation agreement with HIN for data sharing.

Use Case. A specific scenario or group of scenarios for sharing patient health information.

Use Case Exhibit. The legal agreement attached as an exhibit to the Master Use Case Agreement that governs participation in any specific Use Case.

Use Case Implementation Guide (UCIG). The document providing technical specifications related to Message Content and transport of Message Content between participating organizations, MiHIN, and other TDSOs. Use case implementation guides are made available via URLs in exhibits.

Use Case Summary. The document providing the executive summary, business justification and value proposition of a use case. Use case summaries are provided by MiHIN upon request and are available via www.mihin.org.

View Download Transmit. A requirement for Promoting Interoperability with the objective to provide patients with the ability to view online, download and transmit their health information within four business days of the information being available to an Eligible Professional or Organization.

1 Introduction

1.1 Purpose of Use Case

The Quality Measure Information (QMI) use case scenarios enable providers and payers to consolidate and standardize the electronic exchange of quality-related data to enable quality measurement and support quality improvement to close gaps in care.

1.1.1 Quality Measure Information and PPQC

At this time, the burden of collecting, calculating, and reporting quality measure information is borne by physicians and payers (both government and commercial health plans). This quality information is used to measure performance within provider incentive programs and to calculate payer quality measures required by national measure sets such as the Healthcare Effectiveness Data and Information Set (HEDIS), the Quality Rating System (QRS), and electronic Clinical Quality Measures (CQMs) for various federal and state quality reporting programs.

Due to a lack of standards, the electronic formats required by various health plans, federal, and state quality measure reporting programs can vary significantly. These discrepancies add work burdens to physicians and physician organizations because each quality measure must be sent in many different formats to satisfy the requirements of all health plans and programs.

Health plans also suffer from this lack of streamlined processes, as each health plan must cooperate with each physician or physician organization separately to gather the data necessary for each applicable quality measure. As a result, each physician organization establishes its own separate technical connection with every health plan. This creates a point-to-point tangled web of redundancies, inconsistencies, and inefficiencies.

The Physician-Payer Quality Collaborative (PPQC) is a multi-stakeholder initiative including physicians, commercial payers, state Medicaid, and the statewide health information network who are focused on the alignment and streamlining of quality measure processes. It is led by the Michigan State Medical Society (MSMS) with support from Michigan Health Information Network Shared Services (MiHIN).

The PPQC effort was born at the intersection of two stakeholder groups finding common ground.

- The MSMS Executive Council of Physician Organizations surveyed the entirety of its members and discovered quality measure alignment was identified as a top priority for 2015 and beyond.
- MiHIN held a quarterly Payer Day, where commercial and state payers also unanimously identified quality measure processes as a significant pain point needing improvement.

As a result, MSMS and MiHIN partnered to form the PPQC to bring all stakeholders to the table to find solutions to quality measure alignment and pain points. The discussions held within the PPQC led to the concept for the QMI use case. This use case enables providers to consolidate supplemental clinical quality information into a single feed routed through MiHIN. Further, providers participating in PPQC will all use the same standardized reporting format.

MiHIN validates and evaluates this quality information, then distributes it to the appropriate health plans/payers based on those payers' membership information. Payers receive information only for patients who are their members. In this way, payers gain access to a greater quantity and quality of supplemental clinical quality information. Additionally, all the inbound and outbound quality information to/from payers are in a single, statewide standardized format.

In addition, this use case supports quality measure performance feedback to providers from an all-payer/all-patient perspective. MiHIN captures standardized gaps-in-care reports produced by payers, aggregates and then routes the gaps-in-care information back to all providers who have a relationship with that patient.

This standardizes and streamlines the gaps-in-care process, reporting formats, and information transport resulting in more closed gaps-in-care, improved HEDIS scores for health plans, and better care for patients.

QMI Use Case participation in PPQC includes two different activities:

- **Supplemental Data Filtering:** MiHIN receives all-payer supplemental data files in single standard format from participating organizations. MiHIN then separates this information into payer-specific files based on the payer's attributions and routes that data to the appropriate payer, in a single standard format.
- **Report Gaps-in-Care:** Once supplemental data is combined with claims data and processed by payers, the raw results data is sent back to MiHIN, in a standard format. At MiHIN, this raw data is aggregated and distributed back to providers in one consolidated gaps-in-care report.

1.1.2 Population Health and Quality Improvement Registry Use Case Scenario

Data sharing for statewide quality improvement initiatives, such as the Collaborative Quality Initiatives (CQIs) that are funded by Blue Cross Blue Shield of Michigan (BCBSM), are supported by the Quality Measure Information (QMI) Use Case and detailed in the related Population Health and Quality Improvement Registry Use Case Scenario. Please see Appendix A for information specific to this use case scenario.

1.2 Message Content

For QMI participants in PPQC, there are two types of Message Content The All-Payer Supplemental (APS) file contains supplemental clinical quality information from a physician or a physician organization. The other Message Content includes the Standardized Gaps in Care (GiC) file, which includes quality measure gaps in care that are generated from payers for distribution to physicians or physician organizations.

1.3 Data Flow and Actors

Receiving organizations, such as commercial payers and/or state projects, must provide Active Care Relationship Service® (ACRS) files to MiHIN. Patient data contained in the APS files sent by participating organizations will be broken out and matched to eligible receivers' ACRS files. A separate file will be created for each receiver, ensuring that each will only receive data on their patients.

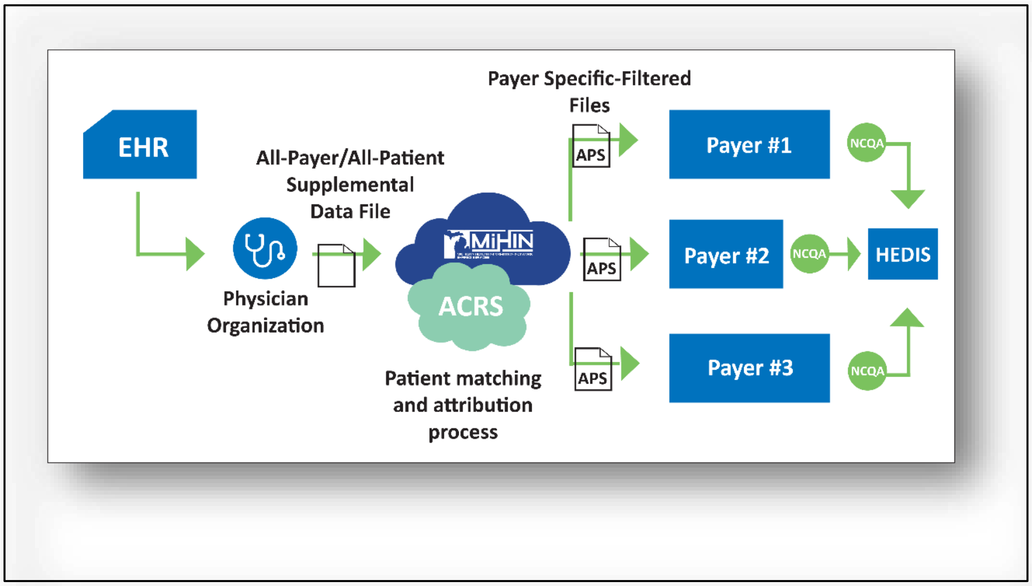


Figure 1. Payer Routing Phase

Once data recipients receive the supplemental data and combine it with claims or supplemental data and calculate quality measures, resulting Gaps-in-Care Reports are generated and submitted to MiHIN, who then determines attribution based on ACRS and shares it with appropriate participating organizations.

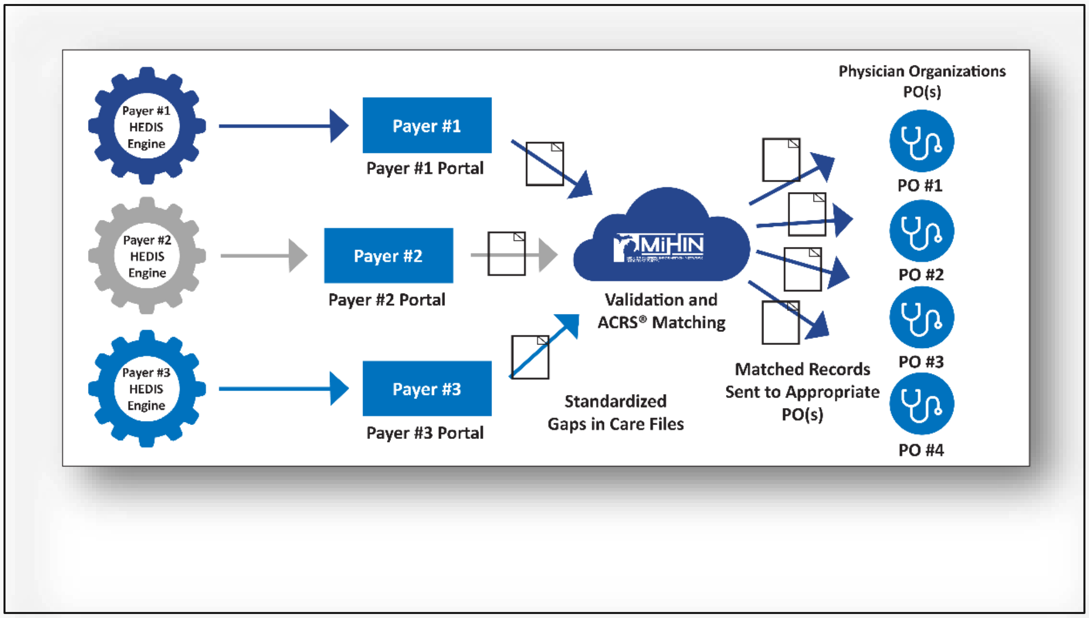


Figure 2. Report Gaps-in-Care

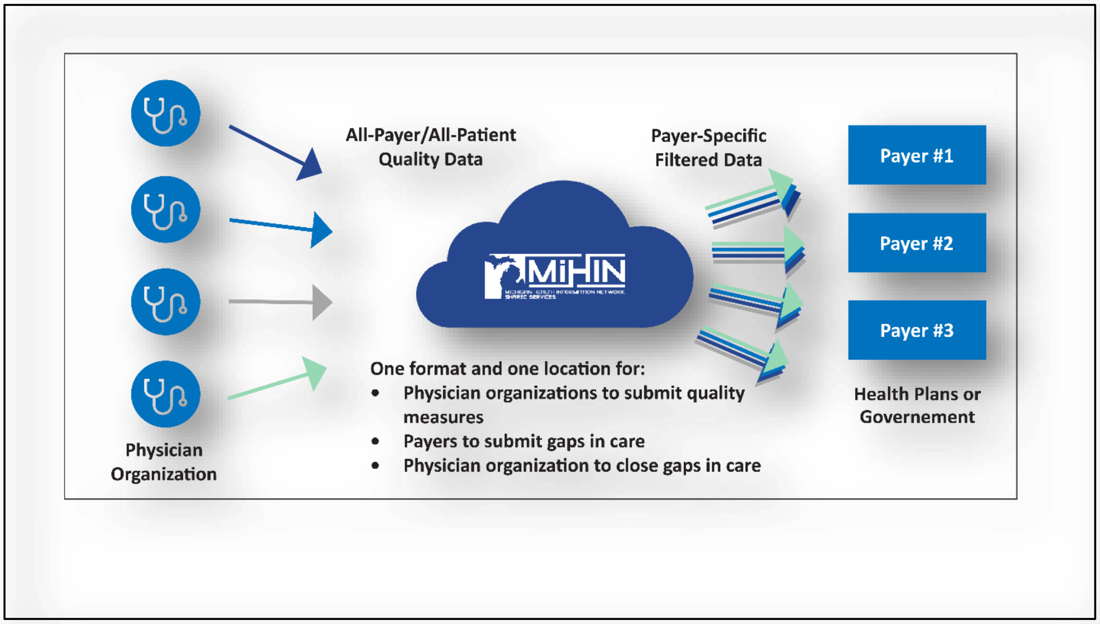


Figure 3. Quality Measure Data Flow

1.3.1 APS File Senders

MiHIN maintains a list of APS file senders that includes all clinical data submitters, their OIDs, organization names, and contact information. This document is maintained on

SharePoint. If you do not have MiHIN SharePoint access, please submit a helpdesk ticket requesting credentials and request access to the PPQC folders.

2 Standard Overview

2.1 Message Format

The current message format supported is the APS format and GiC format, both a pipe-delimited flat files. All quality data files should conform to these specifications. They are available for download here: www.mihin.org/physician-payer-quality-collaborative/

2.2 Message Example

Please see the "Message Examples" tab of the APS spec document for a set of properly formatted example records. Note the file and record level validations performed on the data are also listed in the corresponding tabs in the APS spec document.

3 Onboarding Process

3.1 Initial Onboarding

For organizations participating in PPQC and the QMI Use Case to share data with MiHIN, the organization undergoes a legal and technical onboarding process. Legal onboarding must be complete before technical connectivity onboarding can begin. To initiate the onboarding process, notify MiHIN via http://mihin.org/requesthelp/.

3.1.1 Initial Legal Process

The first time an organization undergoes the legal onboarding process with MiHIN, the organization negotiates and enters into a master participating organization agreement and master use case agreement which then allows the participating organization to enter into one or more use cases via use case exhibits. Once an organization has entered into a master participating organization agreement, the organization can enter into an unlimited number of use cases with MiHIN. All MiHIN's use cases are available at: https://mihin.org/use-case-factory/.

3.1.2 Initial Technical Connectivity Process

MiHIN accepts Secure File Transfer Protocol (SFTP) as the transport method for this use case. For setup, the participating organization completes a SFTP request form (providing IP and account owner information) and is then given a username and password by MiHIN. Alternatively, the participating organization may use an existing MiHIN SFTP account. Participating organization shall then be provided access to an Input and Output folder with MiHIN's SFTP server to drop off or pick up files. Users submitting APS files on behalf of multiple distinct participating organizations will have different folders available for each entity.

3.1.3 Initial Data Validation Process

APS Files

Prior to submitting the initial APS file, the participating organization provides a list of source OIDs which will be contained in the file to MiHIN.

Once an APS file is submitted, feedback is provided via the following mechanisms:

- Email to the address of the SFTP user that submitted to the Input folder:
  - An email will be automatically generated and sent to the address of the SFTP user submitting the file that indicates the outcome of file processing including whether there were "error", "no match", and/or "good" files generated.
- Output files generated and delivered to the Output folder:
  - A given file submission should result in one to three outputs:
    - "error" file: contains the rows of the file that were invalid with an added column indicating the reason for error
    - "no match" file: contains the rows of the file that were valid but that did not match any payers for routing
    - "good" file: contains the rows o the file that were valid and matched to one or more payers with an added column indicating the payer(s) that were matched

Successful receipt of the validation email and return of output files should be verified during onboarding. Error files should be reviewed, and the invalid rows resubmitted once corrections are made. If there are any errors indicating "Invalid OID submitted", the list of OIDs that errored should be verified and then relayed to MiHIN.

Gaps in Care Files

A payer will submit the Gaps in Care file into their Input folder on MiHIN's SFTP server. The files are reviewed to identify any errors and matches with PO ACRS files. Any file rows with errors or where no matches could be found will be batched in an error file and no match file. After processing is complete, the error and no match files will be sent to the MiHIN SFTP server in the payer Output folder for the payer to review.

3.1.4 Initial Message Delivery Verification

Once file submission and validation are established, successful receipt of file deliveries should be confirmed before the participating organization is considered to be in production.

Participating payers or health plans should receive an APS file containing data relevant to the patients in their ACRS file. Participating provider organizations should receive Gaps in Care file data relevant to the patients included in their ACRS file.

4 Specifications

4.1 Message Trigger Events

The APS file should be generated on a schedule determined between the participating organization and MiHIN but will be no less frequent than one file per month.

4.2 File Level Requirements

1. The file must be a text file with suffix ".txt".
2. File name should adhere to the naming convention, with the date being the file creation date: "<SOURCE_OID>_APS_yyyymmdd.txt".
    a. If your organization does not have an object identifier (OID), MiHIN can create one for you. Please reach out to the Help Desk at: www.mihin.org/requesthelp.
3. Fields must be separated by pipes "|".
4. Number of columns contained in the first line (Header) must be exactly three.
5. Number of columns contained in all subsequent lines must be exactly 89.
6. The first file submitted by newly onboarded participating organizations should be a historical file, with subsequent files containing only new data for that month. Historical files are defined as containing data for patients with a measure-dependent look-back period, which can be up to five years or more.

4.3 Specific Record-Level Requirements and Field Definitions

For specific guidance on individual field values and rules, please refer to the specification document for the APS file. You can find a copy of the most up to date APS file specification at the link below.

www.mihin.org/physician-payer-quality-collaborative/

5 Troubleshooting

5.1 Production Support

	Severity Levels			
	1	***2***	***3***	***4***
Description	***Critical Impact/ System Down:*** Business critical software is down, or critical interface has failed. The issue is impacting all production systems, causing all participating organizations' or other organizations' ability to function to be unusable.	***Significant Business Impact:*** Software component severely restricted. Entire organization is unable to continue business functions, causing all communications and transfer of messages to be halted.	**Partial Failure or Downtime:** Program is useable and less significant features unavailable. The service is online, though may not be working as intended or may not currently be accessible, though other systems are currently available.	**Minimal Business:** A non-critical software component is malfunctioning, causing minimal impact, or a test system is down.
Example	All messages to and from MiHIN are unable to be sent and received, let alone tracked	MiHIN cannot communicate (send or receive) messages between single or multiple participating organizations but can still successfully communicate with other organizations.	Messages are lost in transit, messages can be received but not transmitted.	Additional feature requested.
Primary Initiation Method	***Phone:*** 517-336-1430	***Phone:*** 517-336-1430	Web form at http://mihin.org/ requesthelp	Web form at http://mihin.org/ requesthelp
Secondary Initiation Method	Web form at http://mihin.org/ Requesthelp	Web form at http://mihin.org/ requesthelp	Email to help@mihin.org	Email to help@mihin.org
Tertiary Initiation Method	Email to help@mihin.org	Email to help@mihin.org	N/A	N/A
Initial Response	Within 2 hours	Within 2 hours	1 business day	1 business day
Resolution Goal	24 hours	24 hours	3 business days	7 business days

If you are experiencing difficulties or have questions, please contact the MiHIN Help Desk:

- www.mihin.org/requesthelp
- Phone: 517-336-1430
- Email: help@mihin.org
- Monday – Friday 8:00 AM – 5:00 PM (Eastern Time Zone)

6 Legal Advisory Language

This reminder applies to all use cases covering the exchange of electronic health information:

The Data Sharing Agreement (DSA) establishes the legal framework under which participating organizations can exchange messages through the MiHIN Platform, and sets forth the following approved reasons for which messages may be exchanged:

a. By healthcare providers for Treatment, Payment and/or Healthcare Operations consistent with the requirements set forth in HIPAA
b. Public health activities and reporting as permitted by HIPAA and other Applicable Laws and Standards
c. To facilitate the implementation of "Promoting Interoperability" criteria as specified in the American Recovery and Reinvestment Act of 2009 and as permitted by HIPAA
d. Uses and disclosures pursuant to an Authorization provided by the individual who is the subject of the Message or such individual's personal representative in accordance with HIPAA
e. By Data Sharing Organizations for any and all purposes, including but not limited to pilot programs and testing, provided that such purposes are consistent with Applicable Laws and Standards
f. For any additional purposes as specified in any use case, provided that such purposes are consistent with Applicable Laws and Standards

Under the DSA, "***Applicable Laws and Standards***" means all applicable federal, state, and local laws, statutes, acts, ordinances, rules, codes, standards, regulations and judicial or administrative decisions promulgated by any governmental or self-regulatory agency, including the State of Michigan, the Michigan Health Information Technology Commission, or the Michigan Health and Hospital Association, as any of the foregoing may be amended, modified, codified, reenacted, promulgated or published, in whole or in part, and in effect from time to time. "Applicable Laws and Standards" includes but is not limited to HIPAA; the federal Confidentiality of Alcohol and Drug Abuse Patient Records statute, section 543 of the Public Health Service Act, 42 U.S.C. 290dd-2, and its implementing regulation, 42 CFR Part 2; the Michigan Mental Health Code, at MCLA §§ 333.1748 and 333.1748a; and the Michigan Public Health Code, at MCL § 333.5131, 5114a.

It is each participating organization's obligation and responsibility to ensure that it is aware of Applicable Laws and Standards as they pertain to the content of each message sent, and that its delivery of each message complies with the Applicable Laws and Standards. This means, for example, that if a use case is directed to the exchange of physical health information that may be exchanged without patient authorization under HIPAA, the participating organization must not deliver any message containing health information for which an express patient authorization or consent is required (e.g. mental or behavioral health information).

Disclaimer: The information contained in this implementation guide was current as of the date of the latest revision in the Document History in this guide. MiHIN applies its best efforts to keep all information in this guide up-to-date. It is ultimately the responsibility of the participating organization and sending facilities to be knowledgeable of changes outside of MiHIN's control.

7 Provider Participant Privacy Practices

Participation in the QMI Use Case Exhibit will require coordination between the Health Information Network (HIN) and Participant Organization (PO) to address and manage patient education. For organizations who are actively participating in both the QMI Use Case and the Population Health and Quality Improvement Registry Use Case Scenario, Participant Organizations will be responsible for

- Ensuring the patient scaffolding framework is compliant with its sharing practices and existing Policies & Procedures
- Providing a Notice of Privacy Practices outlining for individuals how their information may be used to evaluate the performance of the health care providers and processes involved in their care
- Determining the extent to which changes in the Use Case may be communicated to individuals

Appendix A. Population Health and Quality Improvement Registry Use Case Scenario

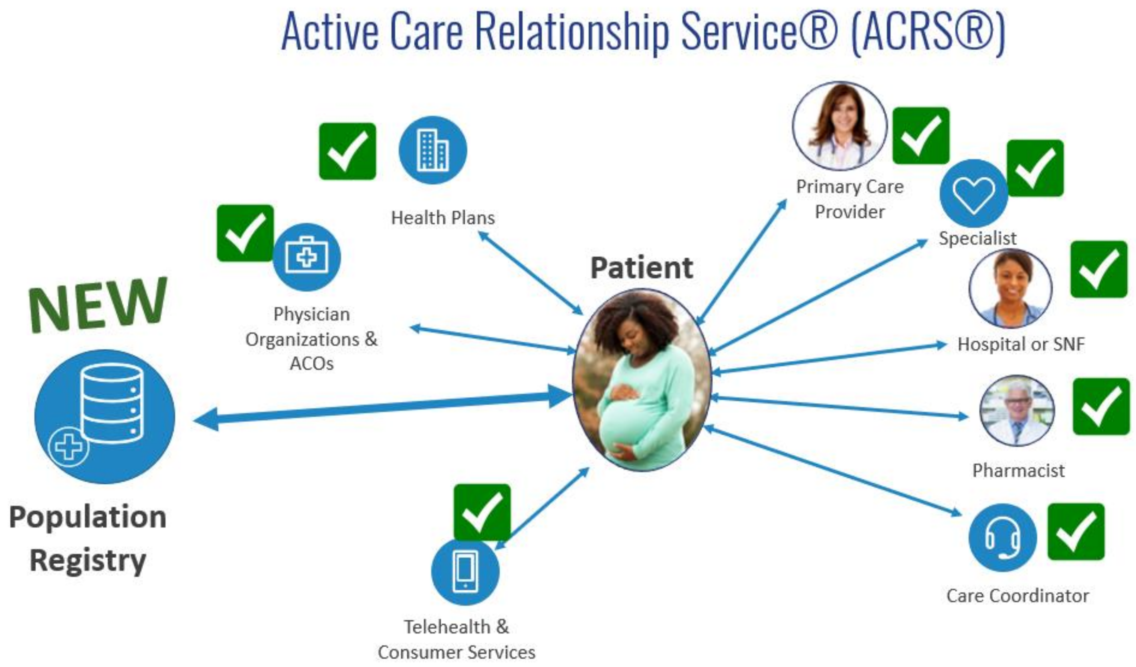
Collaborative Quality Initiatives (CQIs) are all-patient, all-payer, registry-based, physician-led efforts to improve care outcomes in Michigan. The CQIs have historically focused on quality improvement related to procedure or episodic care, such as bariatric surgery or knee and hip replacement. This has primarily involved specialists and care that occurs in acute care settings, with reliance on clinicians to collect data through manually chart abstraction. Given the success of the CQI programs in achieving better clinical outcomes, there was a desire to expand the model to focus on chronic disease at a population health level and to engage POs across the state. To do that requires a different approach to data collection and submission than had been used with the existing CQIs.

Discussions began in 2020 to determine how to leverage existing MiHIN use cases to provide the data needed to support the new Population Health CQIs focused on chronic disease. Through the planning process a data sharing framework was proposed that built off existing MiHIN Use Case Agreements, specifically the ACRS and QMI Use Case Exhibits.

Quality Measure Information (QMI)	Enables participants to send, receive, find, and use data to support a variety of quality measurement and improvement activities
Active Care Relationship Service (ACRS)	Enables patients to be linked with their care team members, including in near real-time based on the content of data received through other MiHIN Use Cases

Those use cases serve as the foundation for the Population Health and Quality Improvement Registry Use Case Scenario, which enables the sharing of data between participants and population registries to support clinical quality measurement and quality improvement initiatives.

This use case scenario applies the Active Care Relationship Service to establish an Active Care Relationship with a population health and quality improvement registry to share data under the health care operations provision of HIPAA, which is where quality improvement activities are covered.



This use case scenario includes two different activities:

- **Scaffolding to identify individuals and sharing data with population registries:** Automating the process to identify individuals for quality improvement programs and populate the registry with relevant clinical, administrative, and social determinants of health-related data from other use cases
- **Sharing care improvement opportunities:** Insights generated from the data aggregated in the population registries can be sent to MiHIN and broadly disseminated to all members of the care team

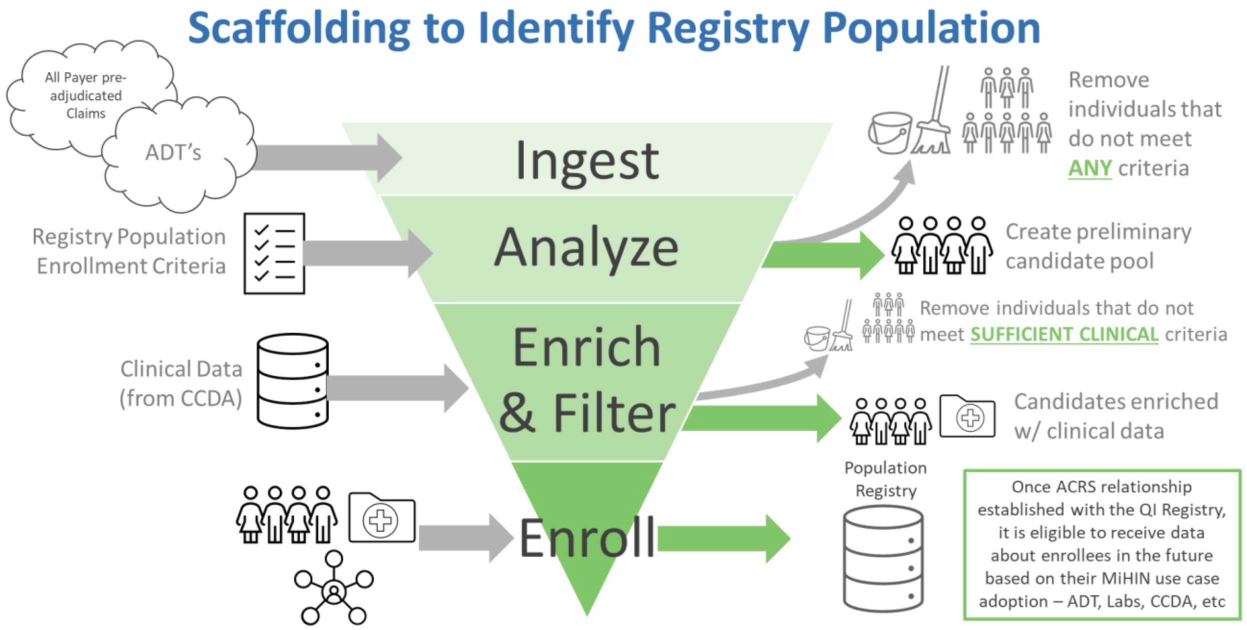
The scaffolding model is a tiered approach to data analysis that starts with more structured data sources to find evidence of a particular condition or disease of interest, and based on that evidence, a more refined focus on capturing data from less structured data sources, like CCDAs, is taken. The key benefit of this approach is that it protects patient privacy by applying the HIPAA Minimum Necessary Standard, limiting the focus of data sharing on only what is important to the cohort of interest versus a detailed review of all data for all individuals that is sent to MiHIN.

The schematic of the scaffolding model is included below.

- The first step in the process is to take the registry population identification criteria and apply it against an initial data source
- 2nd, individuals that do not meet the criteria are removed from further analysis
- 3rd, for individuals where there is evidence that they meet criteria based on the initial data source, additional clinical information that is of relevance to the population cohort of interest is gathered

- Next, an Active Care Relationship is established for the individual and the Registry, and an initial set of data is provided
- The Registry is now considered a part of the care team for that individual, and the is eligible to receive data from other use cases

Different data types and sources may be utilized to support the identification of individuals for population registries, including health claims, ADTs, and APS file information.



The overall data flow for this scenario includes

1. Scaffolding to identify the population
2. Establishing an ACR with the Registry to enroll the patient
3. Sharing an initial bundle of patient data with the Registry
4. Registry subscribes to receive additional data on an ongoing basis
5. Registry can share care insights or gaps in care back to the care team via ACRS

Registry Population Identification, Enrollment and Data Subscription Data Flow